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Meet the Presenters…

On the topic:
Moving from Passive Patients to Self Managed and Engaged

Scott W. Disch, MPH, President of SolveMed Consulting, LLC
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Moving from Passive Patients to Self Managed & Engaged

Presented by
Scott W. Disch, MPH
President & CEO
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Scott W. Disch, MPH

Scott’s been working in acute care hospitals and ambulatory health networks for the past twenty years, of which the latter thirteen have been focused on administration and operational management of physician practices, strategic growth initiatives, population health / risk contract management and development of physician financial and service contractual relationships.

In his various roles within Physician Services, he has garnered experience in revenue cycle management, managed care and value-based risk contracting, physician recruitment, integration, and on-boarding, detailed medical practice operations, and day-to-day adherence to quality outcomes, process efficiency and throughput in the ambulatory setting.

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### Agenda

**"The Why"**
What are we trying to accomplish with Patient Centered Care?

**"The What"**
Educate both Patients & Providers
- 1. How the advanced medical home can be operational in your practice
- 2. Social Determinants of Health - e.g. Loneliness
- 3. Behavioral Health Trust & Technology
- 4. Risk Assessment / Stickiness with patients
- 5. Decision Support
- 6. BHI, Telehealth, CCM - What’s the future hold?

**"The How"**
Engage in the Relationship
- 1. Patient-Centered Care
- 2. Patient as our new payer
- 3. Clinical Decision-Aids
- 4. Standing Orders
- 5. What Artificial Intelligence is doing in the self-mgmt space
- 6. Gamification / App / Platforms

**"The Where"**
Empower Their Needs
- 1. Moving beyond bothering patients for quality measure compliance to engaging in outcomes
- 2. Patient Self-mgmt
- 3. Self-reported data about knowledge of their disease and how they feel about it.
- 4. Non Face-to-Face Interaction - Does it lead to more engagement?
- 5. Crowd-Sourcing / Reviews / Patient Advisors

### Outcomes
- 1. Value of Patient Engagement from Payers (VBID)
- 3. Patient Engagement Waiver for ACO’s
- 4. Patient Loyalty & Attribution
- 5. Episodes of Cost improvement
- 6. Star Ratings - Medicare Advantage

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Our most important relationship is with patients

Health care is increasingly driven by patients. Medical practices and other healthcare organizations are learning to view patients as customers. The patient has become our new payor due to the shift of financial risk from insurance companies over the past five years. Managing a population under a focus of quality, efficiency, and cost will not be effective today without keeping the patient and their relationship with the provider at the focal point of care interventions.

Promoting patient engagement is a win-win situation. This type of engagement is not a promise of a future marriage, but rather a promise, obligation, or other condition that binds the provider and patient medical relationship of trust. Patients are now educated consumers on health care choice, cost, and satisfaction. It is vital that we put the patient FIRST in how we care for their needs and support their interaction with the health care system. Involve your patients and their families with surveys and clinical engagement methods. Develop tools that measure your patients’ satisfaction. Build trust by listening to negative patient feedback and seeking corrective action.
The “Art of Medicine” relationship

MisGuided Care Coordination can lead to poor engagement?

*Ambulatory Care Coordination for just One Patient Requires Advance Coordination*

### What Does PCMH Mean for My Role Day-to-Day?

<table>
<thead>
<tr>
<th>Team Member</th>
<th>Key Day-to-Day Activities</th>
<th>Why it Matters</th>
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</thead>
</table>
| Front Desk  | • Get patients signed up for the portal  
• Encourage patients to fill out the health history form online prior to visit  
• Use the patient cases effectively—know when to elevate issues to the MD | • Supports effective communication with and care access for patients  
• Frees up clinical staff to focus on care management issues |
| Billing Staff | • Use and knowledge of care coordination codes | • Maximizes reimbursement |
| MA          | • Lab reconciliation  
• Queuing up orders  
• Complete intake, thinking ahead and providing as much information to provider as possible | • Streamlines physician interactions with patients  
• Improves speed and efficiency of patient visits and care experience |
| RN          | • Begin instituting care compacts/plans for disease-specific conditions  
• Weekly meetings with MDs to evaluate and plan for management of highest risk patients | • Facilitates team-approach to care management  
• Supports closed-loop on patient tracking and follow-up |
| NP, PA      | • Acting as the quality manager for chronic disease populations  
• Preventative outreach on behalf of the physician  
• Group visit facilitation and management | • Allows for patient-centered care access  
• Actively enables care planning and self-care support for chronic disease populations |
| Physician   | • Releasing day-to-day activities to the staff and empowering them  
• Being the conductor of the team to focus on complex care management | • Maximizes time spent with highest-need patients  
• Improves schedule efficiency  
• Eliminates noise in day-to-day |
### Competencies for Managing Risk

<table>
<thead>
<tr>
<th>Healthcare Economics</th>
<th>Delivery System Architecture/Management</th>
<th>MCO Strategy</th>
<th>Operations and Technology</th>
<th>Private Label Product</th>
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<tbody>
<tr>
<td>• Data gathering</td>
<td>• Physician profiling</td>
<td>• Fee for service</td>
<td>• Practice management system: EMR and HIE</td>
<td>• Exchanges</td>
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<td>• Analytics</td>
<td>• Alignment models/structure</td>
<td>• Bundled payments</td>
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<td>• Medicare Advantage</td>
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<td>• Physician profiling</td>
<td>• Governance</td>
<td>• Professional risk carve out</td>
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<td>• Managed Medicaid</td>
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<td>• Predictive modeling</td>
<td>• Program management</td>
<td>• Global risk</td>
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<td>• Self-insured employers</td>
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<td>• Financial modeling</td>
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<td>• Managed Medicaid</td>
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<td>• Medical cost modeling</td>
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<td>• Medicare Advantage</td>
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<td>• Clinical documentation</td>
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<td>• Exchange products</td>
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<td>• RAF Score monitoring and reconciliation</td>
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<td>• Self-insured market</td>
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### Do you Agree or Disagree with these?

- **Health 1.0 Production**
  - Focus: Evidence based treatment
  - Strategic differentiator: Quality: patient survival

- **Health 2.0 Industrialising**
  - Focus: Value chain management
  - Strategic differentiator: Responsiveness: end-to-end service coverage

- **Health 3.0 Automation**
  - Focus: Operating model
  - Strategic differentiator: Access: cost to serve, efficiency

- **Health 4.0 Digitalisation**
  - Focus: Business model
  - Strategic differentiator: Uniqueness: mass personalisation, proactive healthcare

- **Health 5.0 Personalisation**
  - Focus: Customer model
  - Strategic differentiator: Lifelong partnership: customer wellbeing, quality of life

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Five Stages of Evolution of the Health Sector
US Consumer Priorities of their Healthcare

Maturation process of a risk bearing entity
### Illustrative - Market 5 Year Roadmap

| Phase 1 | Phase 2 | Phase 3 | Phase 4 | Phase 5+
|---------|---------|---------|---------|---------
| **Payer**
North American US
Aggregate physicians
MSSP T1, MIPS
Payer Relationship
Setup JOC
Payer Reimbursement
Leveraged for Care

| **Network**
Our own PCP-based Medical Group
Decide if Specialists needs to be employed (Medical vs. Surgical, Hospital need vs. Medical Group Risk

| **Capabilities**
Practice-Mgmt & ROM
Quality (training, EMR, Coding (training, EMR)
Cost and Reimbursement providers, operational

| **Physician Engagement**
Physician Governance
Physician Reimbursement
Physician Satisfaction
Provider Learning Platform:
Maximize Profit Growth in Line Quality
Utilize Physician-led Lean Quality Improvement Program - Enhanced MD's Risk-Adjusted Performance

| **Patient Engagement**
Patient Portal
Automated Patient Outreach
Online Scheduling
Patient Satisfaction

#### Payer
- **Payer Engagement:**
  - North American US
  - Aggregate physicians
  - MSSP T1, MIPS
  - Payer Relationship
  - Setup JOC
  - Payer Reimbursement
    - Leverage for Care

#### Network
- **Network Engagement:**
  - Our own PCP-based Medical Group
  - Decide if Specialists needs to be employed (Medical vs. Surgical, Hospital need vs. Medical Group Risk

#### Capabilities
- **Capability Engagement:**
  - Practice-Mgmt & ROM
    - Quality (training, EMR)
    - Coding (training, EMR)
    - Cost and Reimbursement providers, operational

#### Physician Engagement
- **Physician Engagement:**
  - Physician Governance
  - Physician Reimbursement
  - Physician Satisfaction
    - Provider Learning Platform:
      - Maximize Profit Growth in Line Quality
      - Utilize Physician-led Lean Quality Improvement Program - Enhanced MD's Risk-Adjusted Performance

#### Patient Engagement
- **Patient Engagement:**
  - Patient Portal
  - Automated Patient Outreach
  - Online Scheduling
  - Patient Satisfaction

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**Social Determinants**

- Health
- Income
- Education
- Housing
- Neighborhood
- Safety
- Employment

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### Additional Information

- **PMI:**
  - Practice Management Institute
  - www.pmiMD.com

- **Webinar/Audio Conference:**
  - October 10, 2018

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**Caveat:**

- Illustrative Roadmap
- Not all items or phases may be applicable to every organization.

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**Notes:**

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**References:**

- [PMI Website](www.pmiMD.com)
- [Webinar/Audio Conference](October 10, 2018)

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**Print Version:**

- [Printable Version](Printable Roadmap)

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**Contact Information:**

- [Contact PMI](Contact PMI)
- [Download Roadmap](Download Roadmap)
Your zip code is more important than your genetic code

Where Income Is Higher, Life Spans Are Longer

As incomes have diverged between the country’s richest counties, like Fairfax County, Va., and its poorest ones, like McDowell County, W.Va., so have the life expectancies of their residents.  

Hotspotting:
The use of data to reallocate resources to a small subset of high-need, high-cost patients

Coldspotting:
Finding communities that lack the essential opportunities for health

COMMENTARY
Cold-Spotting: Linking Primary Care and Public Health to Create Communities of Solution
John M. Westfall, MD, MPH

By providing enhanced primary care and social services to patients with high utilization of expensive emergency and hospital care, there is evidence that their health can improve and their costs can be lowered. This type of “hot-spotting” improves the care of individual patients. It may be that these patients live in communities with disintegrated social determinants of health, little community support, and poor access to primary care. These “cold spots” in the community may be amenable to interventions targeted at linking primary care and public health at broader community and population levels. Building local communities of solution that address the individual and population may help decrease these cold spots, thereby eliminating the hot spots as well. (J Am Board Fam Med 2013;26:239–248.)
How do we approach the social needs?

**Companies that can impact**
1. Commonwealth Care Alliance
2. TavHealth
3. NaviHealth
4. Social ACO’s
5. CareMore

**Legislative or contractual leverage**
1. Classify certain social services as covered benefits under the state’s Medicaid plan
2. Explore the additional flexibility afforded states through Section 1115 waivers
3. Use value-based payment to support investment in social interventions
4. Use incentives and withholds to encourage plan investment in social interventions
5. Integrate efforts to address social issues into quality improvement activities
6. Reward plans with effective investments in social interventions with higher rates

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**Patient Engagement Case Study Discussions**

Case Study #1: McGill University, Canada - Patient Advisor Team Training and Process Redesign
Case Study #2: Saskatchewan Health Region - 100 Patient advisors embedded in committees
Case Study #3: Cincinnati Children’s Hospital - Inflammatory Bowel
Case Study #4: Big White Wall - Mental Health
Case Study #5: Genetic Screening in United Arab Emirates - College Student ambassadors
Case Study #6: India, Mother & Baby Checklist to prevent infant mortality
Case Study #7: Beth Israel Medical Center- patient advisors, patientsite.org

Expectations were different - Patients felt they just scratched the surface and front line caregivers thought they “Killed a monster” with their change of care processes. Why the Disconnect?
Technology Offerings

Technology Connects Our Patients, Providers, and Care Team

- Technology extends capabilities and fills gaps among our industry leading tools (e.g. athena)
- Competitive edge maintained by owning and building our own technology
- Expertise in patient experience yields high engagement rates – 93% of our messages are read
- Scalable platform handles millions of patients, millions of messages every day
- Hosted in a world-class, secure, virtual private cloud
Standing Orders – Update

More Standing Orders, aligned to Pop Health Strategies, are moving towards Production

<table>
<thead>
<tr>
<th>Tactic</th>
<th>Modality</th>
<th>Standing Orders</th>
<th>Volume</th>
<th>Status</th>
<th>Example Trigger</th>
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<td>[Quality] Disease education</td>
<td>Secure message from PCP with Emmi video</td>
<td>10</td>
<td>500/mo</td>
<td>Beta</td>
<td>New diagnosis of COPD</td>
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<td>[Medication Management] New prescription medication education</td>
<td>Secure message from PCP with Emmi video</td>
<td>8</td>
<td>9,000/mo</td>
<td>Beta</td>
<td>New prescription for warfarin</td>
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<td>[Quality] Care gap closure</td>
<td>Chart reconciliation by care team</td>
<td>2</td>
<td>6,800</td>
<td>Alpha</td>
<td>Colonoscopy care gap satisfied by claims data</td>
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<td>[Quality] Care gap closure</td>
<td>MRI calls to patients with 6 or more open gaps</td>
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<td>7,000</td>
<td>Beta</td>
<td>Diabetic patient has six open care gaps</td>
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<td>[Referral steerage]</td>
<td>Secure message from PCP with referral details</td>
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<td>6,300/mo</td>
<td>Production</td>
<td>New referral to cardiology</td>
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<td>[Referral steerage] Shared decision making education</td>
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<td>2,500/mo</td>
<td>Beta</td>
<td>New referral for MRI</td>
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<td>[Acute Events] Transition of Care outreach</td>
<td>Adviser workflow from ED or inpatient ADT notification</td>
<td>2</td>
<td>1,600/mo</td>
<td>Production</td>
<td>Patient discharged from inpatient facility</td>
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<tr>
<td>[Acute Events] Transition of Care outreach</td>
<td>Secure message from PCP with basic appointment module after discharge</td>
<td>2</td>
<td>1,300/mo</td>
<td>Production</td>
<td>Patient discharged from inpatient facility</td>
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<tr>
<td>[Acute Events] Extensivist intervention</td>
<td>Embedded advisory workflow from ED admit notification</td>
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<td>600/mo</td>
<td>Production</td>
<td>Patient admitted to ED</td>
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<td>[Access] ER usage education</td>
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<td>1</td>
<td>1,000/mo</td>
<td>Beta</td>
<td>Patient discharged from ED</td>
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</table>

Responsive Messages Keep Next Steps Top of Mind

**ACO Regularly Pings Patients to Promote Wellness and Loyalty**

**ACO’s Ongoing Messaging Drives Patient Loyalty**

- **Jim has asthma attack**
  - Managed John: ACO texts John to remind him to carry his inhaler today
  - Non-Managed Jim: High pollen count; high-risk day for asthmatics
- **Jim gets costly ED bill; avoids care in future**
  - Managed John: ACO emails John about a lower-cost urgent care near home for next time
  - Jim shops for care: Patient develops rash; goes to ED
- **John knows Privia offers the care he needs; returns for care**

**Impact of Ongoing Messaging on MSSP ACO in 2015**

- **25%**
  - Annual increase in quality scores
- **5.7%**
  - Savings rate
Mobile Engagement

What subsets of the population does this work with?

Secure Check-Ins, Text Messaging and Phone Calls

Mobile Analytics / Risk Assessment

Predictive analytics enable population management
Individualized patterns of change in order to engage

Quantitative and qualitative data aggregation, including patient engagement data and intervention data, identifies patterns and trends to improve population management.

Additional measurements of Engagement

<table>
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<tr>
<th>Clinical</th>
<th>External</th>
<th>Inferred</th>
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<tbody>
<tr>
<td>Supplements from partner Electronic Health Records (EHRs)</td>
<td>Opt-in Social Media content, volume, and frequency</td>
<td>Emotional sentiment of messages with Natural Language Processing (NLP)</td>
</tr>
<tr>
<td>New assessments and screeners</td>
<td>Opt-in Fitness and Activity from Strava, Nike+, and FitBit</td>
<td>Patterning from Care Workflows with Machine Learning (ML)</td>
</tr>
</tbody>
</table>
Patient Decision Aids & Educational Supports

Up-to-Date; Healthwise, Mayo Clinic; Dartmouth

Patient Education Reports: Diabetes

- Triggered based on diagnosis code or abnormal A1c result
- Displays test results relevant to type 2 diabetes management, grouped by comorbidity
- A1c results portrayed in relation to previous results
- Patient friendly explanations and suggestions

Online Presence and SEO

Not only do 72% of patients use the web and online reviews to make decisions about their doctors, but the content also influences Search Engine Optimization.
Listen – Binary Fountain

We've been here twice. The first time our daughter was 6 years old and was covered suddenly in purple hives moving around her body. Triage, registrar, and care were all pretty bad, though it was brief and for we did have to wait a little bit. The other day we were in and out in less than an hour. Our daughter's arm bones popped out of joint and she couldn't move them and cried and said that it hurt whenever she moved her arm. We were less panicked than with the hives, and expected that with a non-threatening condition we might have to wait awhile. I guess part of triage is that they're good at what they can do care of quickly and move those folks along. The docs we saw were super friendly and responsive and the doctor popped our daughter's arm back in with-out her noticing. (They have free books to take home in the ER waiting area and he handed my husband “Horton Hears a Who” to read while making the adjustment. He also even emailed us a video teaching us how to pop her arm bones back in should it occur again.)

Patient Direct Scheduling

Tools allows patients to direct schedule (integrates into provider’s schedule)
Performance Reporting for Actionable Marketing Insights

Value-Based Models Need Patient Engagement
Multi-Prong, In-Market Strategy for Traditional Medicare & Medicare Advantage

Fee-for-Service
- 100% MPFS
- MIPS adj.

MSSP Track 1
- Tracks 1-3
- No Downside
- 50% Upside
- MIPS adj.

MSSP Track 1+2/3
- Downside Risk
- 60-75% Upside
- Track 3 waiver (telehealth)
- MIPS adj.

Next Gen / CMMI
- Alternative payment models (partial, full cap)
- Waivers (3-day SNF, telehealth)
- Emerging benefit, network design models
- APM adj.

Medicare Advantage
- Alternative payment models (partial, full cap)
- Network design
- TIN Split Service
- MIPS / APM

Dual Eligible
- Medicare/Caid State Demos.
- Alternative payment models (partial, full cap)
- Network design
- MIPS / APM

Episode Bundles
- Specialist, Opiphy.
- Upside / Downside
- Episodic Risk
- Ortho, CV
- Hospital-centric
  (today)

Proprietary and Confidential

Quality Measurements in MSSP

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<thead>
<tr>
<th>Category</th>
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<td>Reporting Only</td>
</tr>
<tr>
<td></td>
<td>Depression Remission</td>
<td>EMR</td>
<td>Reporting Only</td>
<td>Reporting Only</td>
<td>Reporting Only</td>
</tr>
</tbody>
</table>

| All-Risk Population          | Depression Remission                            | EMR            | N/A             | Reporting Only  | Reporting Only  |
|                              | Diabetes HbA1C Control                          | EMR            | Reporting Only  | Reporting Only  | Reporting Only  |
|                              | Diabetic Eye Exam                               | EMR            | Reporting Only  | Reporting Only  | Reporting Only  |
|                              | Appropriate Blood-Blocker Use                   | EMR            | Reporting Only  | Reporting Only  | Reporting Only  |
|                              | Appropriate ACRS Use                            | EMR            | Reporting Only  | Reporting Only  | Reporting Only  |
|                              | Blood Pressure Control                          | EMR            | Reporting Only  | Reporting Only  | Reporting Only  |
|                              | Amphetamine-Diamine Use                         | EMR            | Reporting Only  | Reporting Only  | Reporting Only  |
Profile of Successful ACOs (PY 2015)

Percent Of ACOs Earning Shared Savings By Start Date For Performance Years 2013-2015

<table>
<thead>
<tr>
<th>Round</th>
<th>Start Date</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>April 2012</td>
<td>29.60%</td>
<td>34.60%</td>
<td>54.50%</td>
</tr>
<tr>
<td>2</td>
<td>July 2012</td>
<td>32.20%</td>
<td>37.60%</td>
<td>36.50%</td>
</tr>
<tr>
<td>3</td>
<td>January 2013</td>
<td>20.80%</td>
<td>27.20%</td>
<td>37.40%</td>
</tr>
<tr>
<td>4</td>
<td>January 2014</td>
<td>19.30%</td>
<td>22.30%</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>January 2015</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Performance Of ACOs By Size

<table>
<thead>
<tr>
<th>Size</th>
<th>Quintile</th>
<th>Number of ACOs</th>
<th>Mean Number of Beneficiaries</th>
<th>Net Savings/Loss Per Beneficiary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smallest</td>
<td>78</td>
<td>5,608</td>
<td>$114.70</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>78</td>
<td>8,614</td>
<td>$28.21</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>79</td>
<td>12,555</td>
<td>-$34.10</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>78</td>
<td>18,979</td>
<td>-$110.34</td>
<td></td>
</tr>
<tr>
<td>Largest</td>
<td>79</td>
<td>46,692</td>
<td>-$23.93</td>
<td></td>
</tr>
</tbody>
</table>

Rate Of Shared Savings Bonus For Different Types Of ACOs (Hospital Systems, Physician Groups, Or Integrated)

Shared Savings Distribution

SAMPLE CALCULATION:

Attribution: 305

<table>
<thead>
<tr>
<th>Component</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement</td>
<td>$1,531 per provider</td>
</tr>
<tr>
<td>Quality</td>
<td>$22.51 per patient</td>
</tr>
<tr>
<td>Savings Base</td>
<td>$65.68 per patient</td>
</tr>
<tr>
<td>Savings Performance Factor</td>
<td></td>
</tr>
<tr>
<td>Total Bonus</td>
<td>$26,439</td>
</tr>
</tbody>
</table>

Key Performance Variables (Engagement, Quality, Cost) Multiplied by # Attributed Patients
Can they exceed the 70% patient Capture Rate that is desired?

Starting with the AWV visit to engage patients

While AWV compliance is generally high, often it is not differentiated for hotspotters
CPC+ Practices Will Enhance Care Delivery Capabilities

[Examples]

Track 1

- 24/7 patient access
- Assigned care teams
- Risk stratify patient population
- Short and long-term care management
- Identify high volume/cost specialists serving population
- Follow-up on patient hospitalizations

Track 2

- E-visits
- Expanded office hours
- Care plans for high-risk chronic disease patients
- Behavioral health integration
- Psychosocial needs assessment and inventory resources and supports

Access & Continuity

Care Management

Comprehensiveness & Coordination

Direct Primary Care Models - Over 640 locations nationwide

Patient & Physician contractual PMPM Relationship for unlimited PCP services (80% of healthcare needs can be met).

Panel Cap: 500-600 Patients per physician - 10 Per day seen

Overhead reduced to essential team members, supplies, and equipment.

Qliance closed in 2017, but there is a growing DPC interest amongst primary care physicians.

Acknowledgment & Legislation: 18 States have enacted legislation. Kentucky passed new legislation in 2017, West Virginia and Arkansas revised their statutes regarding DPC. Eight other states have pending legislation, and in three of them – Indiana, Colorado and Alabama – the legislation is awaiting only the governor’s signature.

Best Primary Care Practice Attributes:

1) Care Team is always available
2) Choosing Wisely “guideline approach”
3) Rarely outsource, build internal sophistication
4) Action is taken on patient feedback
5) Control the loop with network
6) Invest in People / Work side-by-side
7) Compensation alignment to value

https://www.dpcare.org
How do we impact “Unnecessary” care?

Unnecessary spend represents a rallying cry opportunity to mobilize the network

Key Performance Outcomes

1. Value of Patient Engagement from Payers (VBID)
3. ACO Size & Geography Matter
4. Patient Engagement Waiver for ACO’s
5. Patient Loyalty & Attribution Growth
6. Downside Risk Patient Cost
7. Episodes of Cost improvement
8. Star Ratings - Medicare Advantage
Resources


"Patient Engagement: Four Case Studies that Highlight the Potential for Improved Health Outcomes & Reduced Costs", Health Affairs. By Jeremy Laurance, Sarah Henderson, Peter J. Howitt, Mariam Matar, Hanan Al Kuwari, Susan Edgman-Levitan, and Ana Darzi